# Documentation of Tdap Administration

## Optional Form for Health Care Providers

STUDENT NAME (Last, First, Middle)

| DATE OF Tdap<br>___ ___ / ___ ___ / 2 0 ___ ___<br>MM DD YYYY | NAME OF CHILD'S PHYSICIAN OR AGENCY WHERE Tdap ADMINISTERED |
|---|---|
| DATE OF BIRTH<br>___ ___ / ___ ___ / ___ ___ ___ ___<br>MM DD YYYY | |

*signature not required*

*Other provider documentation of a history of Tdap administration (e.g., 'yellow card', registry or medical records) will be accepted.*

American Academy of Pediatrics
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California District IX

CALIFORNIA ACADEMY OF
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